LEVEL OF CARE REVIEW INSTRUMENT

The assessment cannot be more than six (6)-months old.
(Use Instructions on page three to complete this form correctly.)

SSN #: _____ AIDS Waiver? ☐ Yes ☐ No Assessment Date (MM/DD/YYYY): _____

Last Name: _____ First Name: _____ MI: _____ Suffix (circle): Mr. / Ms./ Mrs.

Enrollee ID # (Recipient): _____ Age: _____ Enrollee Ph: ( ) _____

Provider ID #: _____ Provider Phone #: ( ) _____

If the recipient receives more than one service from your agency, you only need to fill out one form but list all provider numbers in the area above.

Enrollee Address: _____ City: _____ Zip: _____

WAIVER

Recipient Admission Date (Start of care date with service provider): _____ (MM/DD/YYYY)

☐ EDCD (*Specific service(s), check all that apply*): ☐ Personal Care ☐ Respite Care ☐ ADHC ☐ PERS

☐ CDPAS Personal Care ☐ CDPAS Respite Care

☐ AIDS (*Specific service, check all that apply*): ☐ Case Management ☐ Enteral Nutrition ☐ PDN

☐ Personal Care ☐ Respite Care ☐ Consumer-Directed

DEMOGRAPHICS (COMPLETE ALL SECTIONS)

Case Mgmt: _____ Transport: _____ Housing: _____ Congregate: _____ Marital Status: _____ Subst Abuse: _____

Home Repairs: _____ Com of Needs: _____ Personal Care: _____ Home Deliver: _____ Adult Protect: _____

Hearing Impaired: _____ Vocational: _____ Respite: _____ Home Health: _____

Adult Daycare: _____ Other Services: _____

FINANCIAL RESOURCES (CHECK APPROPRIATE BOXES)

Medicaid Insure: ☐No - 0 ☐ Yes - 1 Medicare Insure: ☐ No - 0 ☐ Yes - 1 Medicaid Pending: ☐ No - 0 ☐ Yes - 1

PHYSICAL ENVIRONMENT / FUNCTIONAL STATUS (CHECK APPROPRIATE LEVEL – ONLY 1 CHECK PER ROW)

ADLs (Check appropriate level)	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist 32	Always Performed By Others - 40	Not Performed At All - 50
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

Continence (Bowel/Bladder)	Continent 00	Incontinent (Less than weekly) - 1	External Device/ Indwelling/Ostomy (Self care) – 2	Incontinent (Weekly or more) 3	External Device (Not self care) 4	Indwelling Catheter (Not self care) - 5	Ostomy 6
Bowel							
Bladder							

Mobility (Check appropriate level)	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist. 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist. 32	Confined Moves About 40	Confined - Does Not Move About 50

IADLs				
	Meal Prepare: ☐ N-0 ☐ Y-1	Housekeeping: ☐ N-0 ☐ Y-1	Laundry: ☐ N-0 ☐ Y-1	Money Mgmt: ☐ N-0 ☐ Y-1
	Transport: ☐ N-0 ☐ Y-1	Shopping: ☐ N-0 ☐ Y-1	Using Phone: ☐ N-0 ☐ Y-1	Home Maintenance: ☐ N-0 ☐ Y-1

PHYSICAL HEALTH ASSESSMENT (CHECK APPROPRIATE LEVEL)

Joint Motion

☐ Within normal limits or instability corrected – 0
☐ Limited motion – 1
☐ Instability uncorrected or immobile - 2

Med. Administration / Take Medicine

☐ Without assistance – 0
☐ Administered/monitored by lay person – 1
☐ Administered/monitored by professional nursing staff - 2

Orientation **(Check appropriate box)**	Oriented-0	Disoriented-Some Spheres/SomeTimes -1	Disoriented-Some Spheres/All Times-2	Disoriented-All Spheres/Some Times-3	Disoriented-All Spheres/All Times-4	Semi-Comatose /Comatose-5
Behavior **(Check appropriate box)**	Appropriate 0	Wandering/Passive Less than Weekly 1	Wandering/Passive Weekly or more 2	Abusive/Aggressive/ Disruptive Less than Weekly - 3	Abusive/Aggressive/ Disruptive Weekly or more - 4	Semi-Comatose to Comatose - 5

Ambulation	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist 32	Always Performed By Others - 40	Not Performed At All - 50
Walking								
Wheeling								
Stair climbing								
							Confined Moves About	Confined D/N Move About
Mobility								

PSYCHO-SOCIAL ASSESSMENT (CHECK APPROPRIATE BOX)

Hospitalization or Alcohol/Drug Center: ☐ NO – 0 ☐ YES - 1

ASSESSMENT SUMMARY (CHECK APPROPRIATE ANSWERS)

Is there an informal caregiver? ☐ NO – 0 ☐ YES - 1 | Caregiver Support: ☐ Adequate - 0 ☐ Not Adequate - 1

If No Informal Caregiver or Caregiver Support Not Adequate – List backup plan:

Where does the caregiver Live? ☐ With client - 0 ☐ Separate residence, close proximity – 1 ☐ Separate residence, over 1 hour away - 2

MEDICAL / NURSING NEEDS (COMPLETE ALL SECTIONS)

Diagnosis: _____

Current Health Status/Condition/Comments: _____

_____

_____

Current Medical Nursing Need(s) – Check all items that apply:

1 ☐ Application of aseptic dressings (a)
2 ☐ Routine catheter care (b)
3 ☐ Respiratory therapy (c)
4 ☐ Therapeutic exercise and positioning (d)
5 ☐ Chemotherapy (e)
6 ☐ Radiation (f)
7 ☐ Dialysis (g)
8 ☐ Suctioning (h)
9 ☐ Tracheotomy care (i)
10 ☐ Infusion Therapy (j)
11 ☐ Oxygen (k)
12 ☐ Routine skin care to prevent pressure ulcers for individuals who are immobile. (l)
13 ☐ Care of small uncomplicated pressure ulcers, and local skin rashes (m)
14 ☐ Use of physical (e.g., side rails, poseys, locked wards) and/or chemical restraints. (n)
15 ☐ Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability (o)
16 ☐ Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder (p)
17 ☐ Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration (q)
18 ☐ The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals. (r)
19 ☐ Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists. (s)

 Recipient Name: _____

AIDS Waiver Only: AIDS/HIV diagnoses: ☐ Yes ☐ No

PC/RC - Weekly Hours: _____ ADHC - Number of Days Per Week: _____

Comments: _____

_____

_____

_____ _____

Signature of Person completing the DMAS-99C **Date the DMAS-99C was completed** (MM/DD/YYYY)

_____ _____

Print legibly Name & Title **If this form is not being completed by the RN – Print legibly the name of the RN who made the referenced visit**

INSTRUCTIONS FOR COMPLETING THE DMAS-99C

1. A copy of this form (DMAS-99C) must be completed in its entirety for each current waiver recipient that is admitted under your agency's Medicaid provider number. The instructions to fill out each category correctly are explained below. If you need further instructions about the meaning of a question on this form, look at the UAI manual located at: www.dmas.state.va.us.
2. The provider must attach a copy of the recipient's current: Provider Agency Plan for Personal & Respite Care (DMAS-97A), Consumer-Directed Services Plan of Care (DMAS-97B), the Adult Day Health Care Interdisciplinary Plan of Care (DMAS-301), or the AIDS Waiver Case Management Plan of Care (DMAS-114).
3. The forms are to be mailed to DMAS within the time frame designated on the cover letter. Each provider will receive a cover letter with a list of current recipients and a due date to mail all requested documentation. Due to HIPAA requirements, we cannot accept the forms through electronic mail. In addition, due to the volume, we request that you do not fax the documents, but send them through the U.S. Mail to: The Department of Medical Assistance Services
   F&HBSU – Level of Care Reviews
   600 East Broad Street, Suite #1300
   Richmond, VA 23219
4. **Assessment Date**: The date that the RN did the last 6-month Assessment that is being used to fill this form out.
5. **Waiver**: Check the waiver and the service(s) the recipient is receiving in the waiver.
6. **Demographics**: Place a Yes or No for the four following categories and the other categories not specifically listed below.
   Congreg: Does the client receive congregate meals outside the home? Yes or No
   Home Deliver: Does the client receive meals delivered to his home? Yes or No
   Hearing Impaired: Does the client have a hearing impairment of any type? Yes or No
   Transport: Does the client have current formal paid transportation? Yes or No
   Place the appropriate number following each of the three categories.
   Housing: 0-Own House; 1-Rent House; 2-House Other; 3-Apartment; 4-Rented Room
   Marital Status: 0-Married; 1-Widowed; 2-Separated; 3-Divorced; 4-Single; 9-Unknown
   Com of Needs: 0-Verbally in English; 1-Verbally in Other Language (write in language spoken); 2-Sign Lang/Gestures/Device; 3-Does not Communicate.
7. **Financial Resources**: Check the appropriate box.
8. **Physical Environment / Functional Status:** Check only one box in each category. (Do not write in comments in this section).
   ADLs: Check the appropriate box. Continence / Bowel & Bladder: Check the appropriate box.
   IADLS: Check the appropriate box. These items pertain to whether the client needs help in these areas.
   Mobility: Check the appropriate box.
9. **Physical Health Assessment:** Check the appropriate boxes. (Do not write in comments in this section).
10. **Psycho-Social Assessment**: Check appropriate box. (Do not write in comments in this section).
11. **Assessment Summary**: Check appropriate boxes. (Do not write in comments in this section unless explaining backup plan).
12. **Medical / Nursing Needs:** Describe the current health status/condition of the recipient and check the medical nursing need or write down the nursing need(s) of the recipient. Something must be checked to show recipient's Medical/Nursing eligibility.
    AIDS Waiver Only: Check the appropriate box. Aide's Weekly Hours: The number of weekly hours on the Plan of Care.
    Aide's Number of Days Per Week: The number of days a week that the Plan of Care schedules the aide to work.
13. **Comments:** Any information on the recipient's care, medical condition, or status that relates to his eligibility or utilization of hours.
14. **Reference:** Refer to Chapter 4 - exhibits of the Waiver Manual for eligibility criteria prior to completing this form.
15. **DO NOT leave sections blank - complete the entire form. Read and follow all directions carefully.**

 Recipient Name: _____